Moldova Demographic and Health Survey 2005

Preliminary Report

Moldova Ministry of Health and Social Protection

National Scientific and Applied Center
for Preventive Medicine

Chisinau, Moldova

MEASURE *DHS*
ORC Macro
Calverton, Maryland, USA

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DEMOGRAPHIC AND HEALTH SURVEY
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CONTENTS

I. INTRODUCTION

Moldova's first Demographic and Health Survey (MDHS) was carried out by the National Scientific and Applied Center for Preventive Medicine, hereafter called the National Center for Preventive Medicine (NCPM), of the Ministry of Health and Social Protection. ORC Macro provided technical assistance to the MDHS through the USAID-funded MEASURE DHS program. Local costs of the survey were also supported by USAID, with additional local funding received from the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), and in-kind contributions from the NCPM.

Data collection was conducted from June 13 to August 18, 2005 from a nationally representative sample of over 11,000 households. All women age 15-49 in these households and all men age 15-59 in a subsample of one-third of the households were eligible to be individually interviewed. In addition to the data collected through interviews with these women and men, capillary blood samples were collected from all women age 15-49 and all children age 6-59 months for anaemia testing.

The 2005 MDHS is designed to provide data to monitor the population and health situation in Moldova. Specifically, the 2005 MDHS collected information on fertility levels, marriage, sexual activity, fertility preferences, knowledge and use of family planning methods, breastfeeding practices, nutritional status of women and young children, childhood mortality, maternal and child health, and awareness and behaviour regarding AIDS and other sexually transmitted infections. Additional features of the 2005 MDHS include the collection of information on international emigration, domestic violence, and haemoglobin testing to detect the presence of anaemia. The information collected in the 2005 MDHS provides updated estimates of an array of demographic and health indicators that will assist in the development of appropriate policies and programs to address the most important health issues in Moldova.

The purpose of this report is to highlight some of the preliminary findings from the 2005 MDHS. Where possible, information on trends is documented using indicators estimated from previous surveys in Moldova, namely, the 1997 Reproductive Health Survey (RHS) and the 2000 Multiple Indicators Survey (MICS). Likewise, comparisons with indicators in other countries in the region are made where there has been a DHS or RHS survey; however, the reader should bear in mind the 3- to 9-year time interval between these survey dates and the 2005 MDHS. A comprehensive analysis and presentation of detailed findings will be published early next year in the final report.

II.   SURVEY IMPLEMENTATION

A.   Sample Design

The 2005 Moldova Demographic and Health Survey is based on a representative probability sample of over 11,000 households. This sample was selected in such a manner as to allow separate urban and rural estimates for key population and health indicators, e.g., fertility, contraceptive prevalence, and infant mortality for children under five. Transnistria, the semi-autonomous region in the eastern part of the country accounting for approximately 15 percent of Moldova's population, is not included in the sample.

The 2005 MDHS utilised a two-stage sample design. The first stage involved selecting a sample of cluster sectors from an updated master sampling frame constructed from the 2004 Moldova Population and Housing Census. A total of 400 clusters in Moldova were selected from the master sampling frame. Clusters for urban and rural domains (233 urban and 167 rural) were selected using systematic sampling with probabilities proportional to their size. The distribution of clusters between urban and rural domains is not proportional to the 2004 census distribution, and consequently neither is the final household distribution. The 2005 MDHS is, therefore, not a self-weighted household sample. A final weighting adjustment procedure was carried out to provide estimates at the national level.

A complete household listing operation was carried out from early April to late May 2005 in all of the selected clusters in order to provide a sampling frame for the second stage selection of households. The second stage selection involved the systematic selection of households from a complete listing of all households in each of the 400 clusters. The sample "take" in both urban and rural clusters was 30 households.

All women age 15-49 in the total sample of households, and all men age 15-59 in a subsample of one-third of households, who were either usual residents of the households in the MDHS sample or visitors present in the household on the night before the survey were eligible to be interviewed in the survey.

B.   Questionnaires

Three questionnaires were used for the 2005 MDHS: the Household Questionnaire, the Women's Questionnaire and the Men's Questionnaire. The contents of these questionnaires were based on model questionnaires developed by the MEASURE DHS programme.

Consultations with partners were held in Chisinau to obtain input from various national and international experts on a broad array of issues. Based on these consultations, the DHS model questionnaires were modified to reflect issues relevant in Moldova concerning population, women and children's health, family planning, and other health issues. After approval of the final content by the steering committee, these questionnaires were translated from English into Romanian and Russian.

The Household Questionnaire was used to list all the usual members and visitors in the selected households and to identify women and men who were eligible for the individual interview. Basic information was collected on the characteristics of each person listed, including their age, sex, education, and relationship to the head of the household. In addition, a separate listing and basic information on former household members who had emigrated abroad was collected. The Household Questionnaire was also designed to collect information on characteristics of the household's dwelling unit, such as the source of water, type of toilet facilities, materials used for the floor and roof of the house, ownership of various durable goods, etc. Finally, height and weight measurements, and the results of haemoglobin measurements for consenting women age 15-49 years and children age 6 to 59

months were recorded in the Household Questionnaire. The haemoglobin testing procedures are described in detail in the next section.

The Women's Questionnaire was used to collect information from all women age 15-49. These women were asked questions on the following topics:

- background characteristics (education, residential history, media exposure, etc.);
- reproductive history;
- knowledge and use of family planning methods;
- fertility preferences;
- antenatal and delivery care;
- breastfeeding and infant feeding practices;
- vaccinations and childhood illnesses;
- marriage and sexual activity;
- woman's work and husband's background characteristics;
- infant and child feeding practices;
- childhood mortality; and
- awareness and behaviour about AIDS and other sexually transmitted infections (STIs).

The Women's Questionnaire had a number of important additions compared with the DHS model questionnaire. First, a series of questions were incorporated to obtain information on women's experience of domestic violence. These questions were administered to one woman per household. In households with two or more eligible women, special procedures were followed in order to ensure that there was random selection of the women to be interviewed with these questions.

Another addition to the Women's Questionnaire was a vaccination module for each child under the age of 5 years to be completed at the local health clinic. According to child health experts, immunization information is more frequently kept at the health clinic than on a health card in the mother's possession. The purpose of this module was, therefore, to collect information on immunizations from the local health clinic in addition to that collected during the woman's interview. The vaccination module provides better quality immunization indicators because information gathered during the interview is augmented with information from the local health clinic.

Closely related to the Women's Questionnaire is the caretaker module. This separate module contains the same set of child health questions as those in the Women's Questionnaire regarding immunizations, childhood illnesses such as fever and diarrhoea, and nutrition. The purpose of this module is to gather information on children under age 5 years whose mother does not live in the selected household or is not available to be interviewed. Child health experts believe that, due to high rates of young women emigrating, a significant number of children have been left behind to be cared for by the extended family.

The Men's Questionnaire was administered to all men age 15-59 living in every third household in the MDHS sample. The Men's Questionnaire collected much of the same information found in the Women's Questionnaire, but was shorter because it did not contain questions on reproductive history, maternal and child health, nutrition, and domestic violence.

All aspects of the MDHS data collection were pretested in April 2005. Twenty-six people with medical backgrounds and other specialities were trained for two weeks and then dispatched to conduct interviews in Romanian and Russian, carry out haemoglobin testing, and take height and weight measurements. Over 200 households in urban and rural areas were interviewed in the pretest. The lessons learned from the pretest were used to finalize the survey instruments and logistical arrangements. The major changes as a result of the pretest were incorporation of the caretaker module described above and soliciting the assistance of local medical personnel in each cluster to introduce field personnel to selected households. The latter served to improve household response rates, especially in urban areas.

C.   Haemoglobin Testing

Haemoglobin testing is the primary method of anaemia diagnosis. Reliable measures are obtained using the HemoCue system. In all households selected for the 2005 MDHS survey, women age 15-49 and children age 6 to 59 months were tested for anaemia. A consent statement was read to the eligible respondent or to the parent or responsible adult for children and young women age 15-17. This statement explained the purpose of the test, informed them that the results would be made available as soon as the test was completed, and requested permission for the test to be carried out.

Before taking any blood, the finger was wiped with an alcohol swab and allowed to air dry. Then, the palm side of the end of a finger was punctured with a sterile, non-reusable, self-retractable lancet and a drop of blood collected on a HemoCue microcuvette, which serves as a measuring device, and placed in a HemoCue photometer which displays the result. An informative brochure was given to each household explaining what anaemia is, its symptoms, and measures to prevent anaemia. Each person whose haemoglobin level was lower than the recommended cutoff point was given a written referral recommending immediate follow up with a health professional.

D.   Training

Fieldwork training began on May 16, 2005 in Chisinau and lasted three weeks. A total of 96 training participants were trained as field staff supervisors, editors, and interviewers. In addition, 12 data entry operators and two office editors attended the training. All field staff were also trained as technicians to conduct haemoglobin testing. Most of the participants had a medical background and several had prior experience as interviewers for the UNICEF Multiple Indicator Survey (MICS 2000). Interviewer training was conducted mostly in Romanian by senior staff from NCPM with technical input from ORC Macro. In addition, resource persons from other agencies made presentations on Moldova's programme for family planning, maternal and child health, HIV/AIDS, and gender issues including domestic violence. All participants were trained on interviewing techniques and the contents of the MDHS questionnaires. The training was conducted following the standard DHS training procedures, including class presentations, mock interviews, and written tests. All of the participants were trained on how to complete the Household Questionnaire, the Women's Questionnaire and the Men's Questionnaire. In addition to in-class training, participants practiced taking anthropometric measures and conducting anaemia testing on consenting women and children at local health clinics. They also spent several days in practice field sites interviewing in both languages and carrying out all fieldwork activities. While both female and male interviewers interviewed respondents for the Household Questionnaire, only female interviewers interviewed respondents eligible for the Women's Questionnaire and only male interviewers for the Men's Questionnaire. Participants selected as field supervisors and editors were given an additional two days of training on how to supervise fieldwork and edit questionnaires.

E.   Fieldwork

Fifteen teams were organized for fieldwork. Each team was made up of a field supervisor, an editor, three female interviewers, and one male interviewer. The field staff was selected on the basis of assessments of in-class participation, field practice, fluency in languages, and capacity to conduct interviews as well as anaemia testing. The most experienced participants, namely those who had participated in the pretest and those who did very well in the main survey training, were selected to be supervisors and editors.

Senior staff from the NCPM coordinated and supervised all aspects of fieldwork activities. ORC Macro followed fieldwork progress by receiving approximately every two weeks a standard set of quality control tables generated from the most recent accumulation of data. Data collection took place for just over two months, from June 13 to August 18, 2005. On average, each team completed one

cluster over two full days, taking advantage of early mornings and late evenings to find respondents at home.

F.   Data Processing

The processing of the MDHS results began shortly after the fieldwork commenced. Completed questionnaires were returned weekly from the field to the NCPM headquarters in Chisinau, where they were entered and edited by data processing personnel who were specially trained for this task. Data were entered using CSPro, a programme specially developed for use in DHS surveys. All data were entered twice (100 percent verification). The concurrent processing of the data with ongoing data collection was a distinct advantage for data quality since NCPM had the opportunity to advise field teams of problems detected during the data entry. The data entry and editing phase of the survey was completed in late August 2005.

III. RESULTS OF THE SURVEY INTERVIEWS

A. Response Rates

Table 1 shows response rates for the 2005 MDHS. A total of 12,206 households were selected in the sample, of which 11,649 were occupied at the time of the fieldwork. This difference between selected and occupied households is largely due to structures that were found to be vacant. The number of occupied households successfully interviewed was 11,095, yielding a household response rate of 95 percent.

Table 1. Results of the household and individual interviews			
Number of households, number of interviews, and response rates, according to residence, Moldova 2005			
	Residence		
Result	Urban	Rural	Total
Household interviews			
Households selected	7,104	5,102	12,206
Households occupied	6,707	4,942	11,649
Households interviewed	6,227	4,868	11,095
Household response rate	92.8	98.5	95.2
Individual interviews: women			
Number of eligible women	4,602	3,224	7,826
Number of eligible women interviewed	4,301	3,139	7,440
Eligible women response rate	93.5	97.4	95.1
Individual interviews: men			
Number of eligible men	1,698	1,199	2,897
Number of eligible men interviewed	1,417	1,091	2,508
Eligible men response rate	83.5	91.0	86.6

In the households interviewed in the survey, a total of 7,826 eligible women were identified; interviews were completed with 7,440 of these women, yielding a response rate of 95 percent. In a subsample of one-third of households in the MDHS sample, a total of 2,897 eligible men were identified and interviews were completed with 2,508 of these men, yielding a male response rate of 87 percent. As is typically found in other surveys, the response rates are lower for the urban than for the rural sample, and lower among men than women.

The principal reason for non-response among both eligible women and men was the failure to find individuals at home despite repeated visits to the household.

B. Characteristics of Respondents

The distribution of women age 15-49 and men age 15-59 by background characteristics is shown in Table 2. The proportions of both women and men are largest in the younger age groups (age 15-24) and the older age groups (age 45-49 for women, age 45-54 for men). This U-shaped distribution of the Moldovan population reflects the aging baby boom cohort following World War II (the youngest of the baby boomers are now in their mid-40s) and their own children who are now mostly in their teens and 20s. The lower proportions of men and women in the middle age groups reflect the smaller cohorts following the baby boom and preceding the generation of baby boomers' children. To some degree, it also reflects the higher rates of emigration of the working age population.

Table 2. Background characteristics of respondents

Percent distribution of women and men by background characteristics, Moldova 2005

Background characteristic	Women			Men		
	Weighted percent	Weighted number	Unweighted number	Weighted percent	Weighted number	Unweighted number
Age						
15-19	19.0	1,417	1,403	16.4	411	411
20-24	15.1	1,124	1,145	11.0	275	287
25-29	13.0	964	964	9.3	234	241
30-34	12.4	924	918	8.9	224	228
35-39	11.5	855	859	9.9	248	247
40-44	13.5	1,007	1,001	9.9	247	242
45-49	15.4	1,149	1,150	13.9	349	340
50-54	na	na	na	11.8	296	293
55-59	na	na	na	8.9	224	219
Marital status						
Never married	25.0	1,862	1,884	29.1	730	745
Married	61.4	4,565	4,486	62.7	1,573	1,561
Living together	5.0	372	406	3.4	85	83
Divorced/separated/widowed	8.6	641	664	4.8	120	119
Residence						
Urban	42.9	3,194	4,301	42.0	1,055	1,417
Rural	57.1	4,246	3,139	58.0	1,453	1,091
Region						
North	29.7	2,207	2,065	30.2	756	700
Center	27.3	2,033	1,805	28.0	702	633
South	18.9	1,402	1,443	19.8	496	518
Chisinau	24.2	1,798	2,127	22.1	554	657
Education						
No education	*	17	19	*	3	3
Primary	0.3	22	23	0.5	13	11
Secondary	61.1	4,544	4,339	71.3	1,787	1,713
Secondary special	17.8	1,327	1,372	12.0	302	317
Higher	20.6	1,530	1,686	16.1	403	464
Religion						
Orthodox	94.5	7,030	6,991	93.7	2,351	2,341
Protestant (ex. Evangelical, Baptist, Jehovah Witness)	2.9	217	245	1.9	47	48
Jewish	0.5	40	37	3.7	94	100
Other	2.0	152	165	0.7	16	18
Ethnic group						
Moldovan	77.0	5,727	5,515	75.6	1,896	1,830
Romanian	2.2	167	178	2.5	62	74
Ukrainian	7.9	586	597	8.5	212	207
Russian	6.1	457	563	5.6	140	168
Gagauzan	3.8	283	329	4.5	114	134
Bulgarian	1.9	144	166	2.1	53	62
Other	1.0	77	92	1.1	29	33
Total	100.0	7,440	7,440	100.0	2,508	2,508

Note: Education categories refer to the highest level of education attended, whether or not that level was completed. The total includes one woman for whom educational status was missing.
na = Not applicable
* Replaces figures that are based on fewer than 25 unweighted cases, men and women combined

Nearly two-thirds of women and men (66 percent) are married or living together. Because men tend to marry later in life than women, 29 percent of the surveyed men age 15-59 years have never married, compared with a fourth of the women age 15-49 years. On the other hand, women are more likely than men to be widowed, divorced, or separated (9 percent versus 5 percent).

More women and men live in rural areas than urban areas, and there is little difference in the distribution of women and men by urban-rural residence (57 percent of women and 58 percent of men live in rural areas). By region, the smallest proportion, about one-fifth, of women and men are from the South region.

Women and men in Moldova are universally well educated, with virtually 100 percent having at least some secondary or higher education: 79 percent of women and 83 percent of men have a secondary or secondary special education ("secondary special" education is specialized technical training in a specific field such as nursing, agriculture, construction, etc.), and the remainder pursue a higher education. More women (21 percent) than men (16 percent) pursue higher education.

While most respondents in Moldova are clearly of Moldovan ethnicity and Orthodox religion, there is more variation in ethnicity than in the religion reported by respondents. Most women and men in Moldova are of Moldovan ethnicity (77 percent and 76 percent, respectively), followed by Ukrainian (8 percent of women and 9 of percent men), Russian (6 percent of women and men), and Gagauzan (4 percent women and 5 percent men). Romanian and Bulgarian ethnicities accounted for 2 to 3 percent of men and women.

The overwhelming majority of Moldovans, about 95 percent, report Orthodox Christianity as their religion. Although other religions are a small minority, it appears that a greater proportion of men than women are Jewish and a greater proportion of women than men are Protestant.

C. Children's Living Arrangements

There is wide consensus among child development experts that children are best socialized and provided for within the family context and, under most circumstances, one in which there is strong family unity, including the presence of both parents. The 2005 MDHS collected information on children's living arrangements. Table 3 shows the percent distribution of children under age 15 by their living arrangements and survival status of parents, according to background characteristics.

About one-third of children (31 percent) under age 15 do not live with *both* mother and father, while 13 percent do not live with their mother and 25 percent do not live with their father. Seven percent of children do not live with *either* parent. The great majority of these children are "social orphans," that is, their biological parents are still alive but they have been voluntarily left in the care of other persons. (Note that these indicators do not take into account children who live outside of households e.g., in institutions or on the street, because the MDHS includes only households in its sample.) Results show that just 2 percent have lost their father only, 1 percent have lost their mother only, and virtually none have lost both biological parents. Altogether, 3 percent of children under 15 have lost at least one parent.

Table 3. Children's living arrangements and orphanhood

Percent distribution of de jure children under age 15 by children's living arrangements and survival status of parents, according to background characteristics, Moldova 2005

| Background characteristic | Living with both parents | Living with mother but not father | | Living with father but not mother | | Not living with either parent | | | | | Total | Number of children |
		Father alive	Father dead	Mother alive	Mother dead	Both alive	Only father alive	Only mother alive	Both dead	Missing information on father/ mother		
Age												
<2	81.7	13.8	0.2	0.7	0.3	2.7	0.0	0.0	0.0	0.6	100.0	684
2-4	70.3	16.5	0.9	3.0	0.2	7.9	0.1	0.0	0.0	1.0	100.0	1,019
5-9	66.1	16.3	1.8	4.4	0.3	8.3	0.3	0.4	0.1	1.9	100.0	1,817
10-14	66.8	13.8	3.4	6.0	0.6	6.1	0.4	0.6	0.3	2.0	100.0	2,622
Sex												
Male	67.7	16.2	2.5	5.0	0.6	5.8	0.2	0.1	0.2	1.8	100.0	3,143
Female	70.1	13.7	1.8	3.9	0.2	7.6	0.4	0.6	0.1	1.6	100.0	3,000
Residence												
Urban	67.0	17.7	2.4	3.9	0.3	5.5	0.1	0.4	0.1	2.5	100.0	2,061
Rural	69.8	13.6	2.0	4.7	0.4	7.3	0.4	0.4	0.2	1.3	100.0	4,082
Region												
North	68.6	15.7	2.3	4.3	0.2	6.9	0.3	0.5	0.2	1.0	100.0	1,792
Center	69.6	13.1	2.2	4.6	0.8	7.9	0.2	0.2	0.2	1.1	100.0	1,881
South	67.7	14.3	1.8	5.4	0.2	7.1	0.6	0.6	0.1	2.0	100.0	1,334
Chisinau	69.4	17.6	2.0	3.3	0.3	3.7	0.1	0.3	0.1	3.3	100.0	1,135
Total	68.9	15.0	2.1	4.5	0.4	6.7	0.3	0.4	0.2	1.7	100.0	6,143

Compared with living arrangements of children in 2000, the proportion of children not living with their parents has increased. In 2000, 16 percent of children under age 15 did not live with *both* mother and father, 3 percent did not live with their mother, and 15 percent did not live with their father. Two percent did not live with *either* parent (UNICEF and GOM, 2000).

Not only have children's living arrangements deteriorated since 2000, they are also among the worst in the region. Compared with estimates from recent Demographic and Health Surveys conducted in other countries in Eastern Europe and Eurasia, fewer children live with both of their parents in Moldova than in other countries in the region: in Armenia (1999), 10 percent of children age 0-15 are not living with both mother and father; in Kazakhstan (1999), 19 percent; in Kyrgyz Republic (1997), 15 percent; in Turkmenistan (2000), 12 percent; and in Uzbekistan, 10 percent (ORC Macro, 2005).

D.   Fertility

Fertility data were collected in the 2005 MDHS by asking each of the women interviewed for a history of her births. The information obtained on each of the woman's births included the month and year of the birth. These data are used to calculate two of the most widely used measures of current fertility—the total fertility rate (TFR) and its component age-specific fertility rates (ASFR).

Table 4 shows a TFR of 1.7 children per woman for the three-year period preceding the 2005 MDHS, corresponding to the period from mid-2002 to mid-2005. This means that, on average, a woman in Moldova who is at the beginning of her childbearing years will give birth to 1.7 children by the end of her reproductive period if fertility levels remain constant at the level observed in the three-year period.

Table 4.   Current fertility

Age-specific fertility rates, the total fertility rate, the general fertility rate, and the crude birth rate for the three years preceding the survey, by urban-rural residence, Moldova 2005

| Age group | Residence | | Total |
	Urban	Rural	
15-19	26	39	34
20-24	110	153	132
25-29	91	98	95
30-34	54	59	57
35-39	17	16	17
40-44	2	4	3
45-49	0	0	0
TFR	1.5	1.8	1.7
GFR	51	59	55
CBR	12.5	11.7	12.0

ASFR: Age-specific fertility rate (number of births to women in a specific age group divided by the number of woman-years lived during a given period).
TFR: Total fertility rate for ages 15-49, expressed per woman
GFR: General fertility rate (births divided by the number of women age 15-44), expressed per 1,000 women
CBR: Crude birth rate, expressed per 1,000 population

The TFR for rural areas (1.8 births) is higher than that for urban areas (1.5 births). Figure 1 shows that this urban-rural difference in childbearing rates can be attributed almost exclusively to younger age groups. Although peak fertility occurs sharply at age 20-24 in both urban and rural areas, the greatest absolute difference in ASFR (43) is in the 20-24 age group.

Compared with fertility estimates from recent Reproductive Health Surveys and Demographic and Health Surveys conducted in other countries in Eastern Europe and Eurasia, fertility in Moldova in 2005 is generally higher than in Romania (1.3 in 1999) and Ukraine (1.4 in 1999); similar to fertility in the Caucasus (Armenia 1.7 in 2000, Azerbaijan 2.1 in 1999, and Georgia 1.7 in 1999); and lower than in Central Asia (Kazakhstan 2.1 in 1999, Kyrgyz Rep. 3.4 in 1997, Turkmenistan 2.9 in 2000, and Uzbekistan 3.3 in 1996) (CDC and ORC Macro, 2003).

Figure 1
Age-specific fertility rates by urban-rural residence
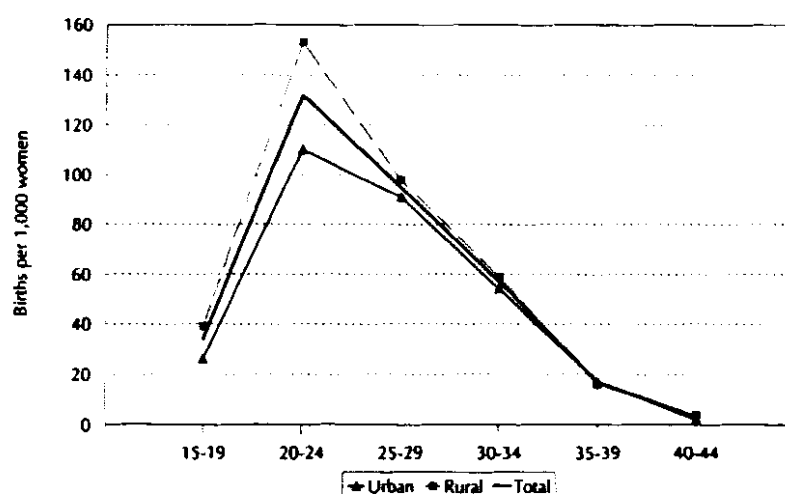
According to information from official sources in Moldova, fertility appears to have *decreased* throughout the 1990s and into the present decade. The Moldova government estimates, excluding Transnistria, indicate a decline in fertility in the 1990s, from a TFR of 1.8 in 1995 to 1.4 in 1999 (Statistica Moldovei, 2000), to 1.3 in 2002 (UNFPA, 2003). The 1997 Reproductive Health Survey estimated the TFR among married women for the three-year period from 1994 to 1997 to be 1.8 (CDC and MOH, 1998).

In light of these estimates indicating a decline in fertility, however, the TFR of 1.7 for all women calculated from the 2005 MDHS suggests fertility may have *increased* in recent years (or stayed the same since the 1997 RHS). The apparent increase is supported by estimates from international agencies monitoring population trends. The International Program Center of the U.S. Census Bureau (2005), for example, estimated an increase in fertility starting after 2000—from a TFR of 1.6 in 2000 to 1.8 in 2005. The question that follows is: Has there been resurgence in fertility, or is the increase explained by a change in the composition of the population? A change in population composition may be related to a significant rate of emigration of young women from Moldova. If women who have fewer or no children are more likely to emigrate, then a larger share of women with children would be left in Moldova, and consequently eligible to be interviewed in the 2005 MDHS sample. A more detailed analysis of fertility and emigration data is necessary to explore the reasons for the apparent increase in fertility rates.

E.   Family Planning

Information about knowledge and use of contraceptive methods was collected from female respondents by asking them to mention any ways or methods by which a couple might delay or avoid a pregnancy. For each method known, the respondent was asked if she had ever used it. Respondents who reported ever using a family planning method were asked whether they or their partner was using a method at the time of the MDHS interview. Table 5 shows the level and key differentials in the current use of contraceptive methods as reported by currently married women.

About two-thirds of currently married women (68 percent) are presently using some method of contraception. Modern methods are more commonly used than traditional methods; 44 percent of

11

married women use modern methods while about 24 percent use traditional methods. The IUD is the most widely used of the modern methods, and it accounts for 25 percent of all methods used. However, compared with data on IUD prevalence from the 1997 RHS (38 percent) and MICS, 2000 (34 percent), the share of women using IUDs appears to be decreasing as other methods become increasingly popular. Male condoms are used by about 7 percent of women, and women in younger age groups use condoms notably more frequently than women in older age groups. Withdrawal is the most popular traditional method. It is used by 20 percent of women and without much variation between age groups (ranging between 17 and 23 percent in all age groups).

Age is an important background characteristic related to the overall level of contraceptive use. Prevalence of use among married women in older age groups is generally higher than for married women under age 30; however, the use of modern methods peaks earlier (age 25-39) than the peak in use of traditional methods (age 40-44).

While the level of any contraceptive use is about the same for women in both urban and rural areas (67-68 percent), women in urban areas are more likely than women in rural areas to use modern methods (48 percent and 41 percent, respectively), and conversely, women in rural areas are more likely than women in urban areas to use traditional methods (27 percent and 19 percent, respectively). In terms of regions, married women use contraception to about the same extent in all regions, ranging from 67 to 69 percent. In Chisinau, as expected, women have a higher prevalence rate of modern methods than in other regions and a lower prevalence of traditional methods than other regions.

Use of contraceptive methods increases with increasing levels of education. For example, 72 percent of married women with higher levels of education are using a method of contraception compared with 65 percent of women with secondary education. Use also tends to increase with the number of living children—from 36 percent among married women with no children to 74 percent among married women with 3 to 4 children.

In terms of trends, in 1997 the contraceptive prevalence rate was 74 percent of married women age 15-44 years, and 50 percent used a modern contraceptive method (CDC and MOH, 1998). Although it appears that contraceptive prevalence has slightly decreased since 1997, one must take into account the different age group of women interviewed in the 2005 MDHS. Interviewing women 15-49 years likely results in a lower prevalence because proportionally fewer women age 44-49 use contraception, especially modern contraception (Table 5).

Compared with estimates of current contraceptive use from recent Reproductive Health Surveys and Demographic and Health Surveys conducted in other countries in Eastern Europe and Eurasia, prevalence in Moldova appears: similar to that in Romania (64 percent in 1999) and Ukraine (68 percent in 1999); and higher than that in the Caucasus (Armenia 61 percent in 2000, Azerbaijan 55 percent in 1999, and Georgia 41 percent in 1999) and in Central Asia (Kazakhstan 62 percent in 1999, Kyrgyz Rep. 60 percent 1997, Turkmenistan 55 percent in 2000, and Uzbekistan 57 percent in 1996) (CDC and ORC Macro, 2003).

Table 5. Current use of contraception

Percent distribution of currently married women by contraceptive method currently used, according to background characteristics, Moldova 2005

Background characteristic	Any method	Any modern method	Modern method							Any traditional method	Traditional method			Not currently using	Total	Number of women
			Female sterilisation	Male sterilisation	Pill	IUD	Male condom	LAM	Other		Periodic abstinence	With-drawal	Folk method			
Age																
15-19	58.4	33.9	0.0	0.0	4.2	11.0	13.6	4.4	0.7	24.5	2.3	22.2	0.0	41.6	100.0	136
20-24	63.1	41.5	0.3	0.0	4.7	17.2	14.4	3.4	1.5	21.7	1.9	19.8	0.0	36.9	100.0	629
25-29	70.7	50.9	2.1	0.0	5.3	26.9	11.3	2.7	2.5	19.9	2.1	17.0	0.8	29.3	100.0	794
30-34	74.9	52.6	3.9	0.0	5.6	30.9	8.9	1.3	1.8	22.3	4.1	17.6	0.6	25.1	100.0	810
35-39	78.3	53.1	7.3	0.0	3.6	34.0	5.9	0.4	1.9	25.2	3.9	20.5	0.8	21.7	100.0	746
40-44	73.5	45.3	7.3	0.2	2.9	30.0	3.6	0.0	1.4	28.2	4.2	22.7	1.3	26.5	100.0	869
45-49	50.2	25.0	6.5	0.0	0.2	15.1	1.9	0.0	1.2	25.3	4.2	19.5	1.5	49.8	100.0	953
Residence																
Urban	67.2	47.8	4.6	0.0	5.0	21.6	12.9	0.9	2.8	19.4	4.9	13.7	0.8	32.8	100.0	2,045
Rural	68.2	41.0	4.7	0.1	2.6	27.8	3.5	1.5	0.9	27.2	2.4	23.8	0.9	31.8	100.0	2,892
Region																
North	69.0	41.5	4.8	0.1	3.4	26.0	5.2	1.0	0.9	27.5	3.4	23.4	0.7	31.0	100.0	1,515
Center	66.7	41.1	4.8	0.0	2.2	27.9	3.5	1.5	1.1	25.6	3.0	21.7	1.0	33.3	100.0	1,336
South	67.3	43.1	4.9	0.0	3.0	28.5	3.8	1.7	1.2	24.2	2.0	21.7	0.5	32.7	100.0	958
Chisinau	67.9	51.0	4.0	0.0	5.9	18.3	17.9	1.0	3.9	16.9	5.3	10.3	1.2	32.1	100.0	1,127
Education																
No education	*	*	*	*	*	*	*	*	*	*	*	*	*	*	100.0	12
Primary	*	*	*	*	*	*	*	*	*	*	*	*	*	*	100.0	19
Secondary	65.4	40.1	5.2	0.0	2.6	25.5	4.6	1.5	0.7	25.2	1.7	22.6	1.0	34.6	100.0	2,894
Sec. special	70.7	47.7	5.6	0.0	4.3	28.5	6.3	0.9	2.0	23.0	4.6	17.7	0.6	29.3	100.0	1,046
Higher	72.2	50.9	2.0	0.2	5.9	21.1	16.4	1.0	4.3	21.3	7.7	12.8	0.7	27.8	100.0	966
Living children																
0	35.7	22.2	0.5	0.0	3.5	0.9	15.8	0.0	1.4	13.5	2.1	11.0	0.4	64.3	100.0	534
1-2	71.3	48.0	4.7	0.0	4.0	28.2	7.6	1.5	2.0	23.3	4.3	18.3	0.7	28.7	100.0	3,435
3-4	74.0	42.3	6.5	0.2	2.2	29.3	1.9	1.2	1.0	31.7	1.5	28.5	1.7	26.0	100.0	875
5+	64.2	29.2	8.4	0.0	2.2	17.4	0.0	1.2	0.0	34.9	0.0	34.9	0.0	35.8	100.0	93
Total	67.8	43.8	4.7	0.0	3.6	25.2	7.4	1.3	1.7	23.9	3.5	19.6	0.9	32.2	100.0	4,937

Note: If more than one method is used, only the most effective method is considered in this tabulation.
LAM = Lactational amenorrhea method.
* Replaces figures that are based on fewer than 25 unweighted cases.

F. Fertility Preferences

The survey included several questions on women's fertility preferences: whether the respondent wanted another child and, if so, when she would like to have the next child. The answers to these questions allow an estimation of the potential demand for family planning services either to space or limit births.

Figure 2 shows that there is considerable desire among Moldovan women to control the timing and number of births. Among all currently married women, 14 percent would like to wait for two years or more for the next birth, and 63 percent do not want to have another or are sterilised. About 12 percent of married women would like to have a child soon (within two years). The remaining women are uncertain about their fertility desires or say they are unable to get pregnant (infecund).

Figure 2
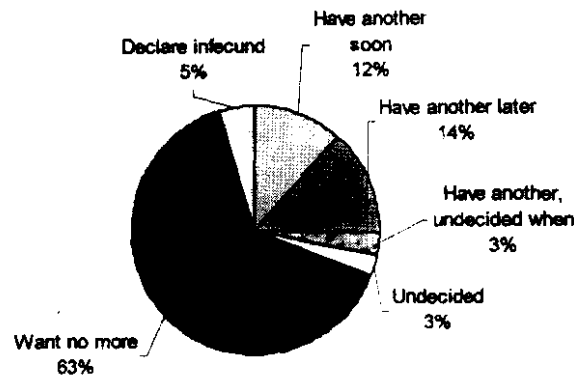**Fertility preferences among currently married women**

Table 6 shows that fertility preferences are closely related to the number of children a woman has. About half of currently married women without a child would like to have one soon. The desire to have another child drops quickly after the first child; only one-fifth of women with one child want to have another soon, a third want to have another child later (after two or more years), and another third do not want any more children. The proportion of women who want no more children rises from 33 percent among women with one child to 77 percent of women with two living children or more and 80 percent and higher for women with three or more living children.

Table 6. Fertility preferences by number of living children

Percent distribution of currently married women by desire for children, according to number of living children, Moldova 2005

Desire for children	Number of living children[1]						Total
	0	1	2	3	4	5+	
Have another soon[2]	48.9	19.0	3.2	1.3	0.7	1.6	11.5
Have another later[3]	19.0	32.7	5.4	2.1	1.2	0.0	13.6
Have another, undecided when	11.0	4.4	1.7	1.0	1.4	0.9	3.2
Undecided	0.9	3.4	2.6	1.3	1.8	4.9	2.5
Want no more	8.6	33.4	76.8	83.3	82.0	79.5	59.4
Sterilized[4]	0.6	2.4	6.2	6.2	7.3	8.4	4.7
Declare infecund	10.1	4.1	4.0	4.9	4.2	3.7	4.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	455	1,394	2,094	692	210	93	4,937

[1] Includes current pregnancy
[2] Wants next birth within 2 years
[3] Wants to delay next birth for 2 or more years
[4] Includes both male and female sterilisation

G.   Maternity Care

Proper care during pregnancy and delivery are important for the health of both the mother and the infant. In the 2005 MDHS, women who had given birth in the five years preceding the survey were asked a number of questions about maternal and child health care. For the last live birth in that period, the mothers were asked whether they had obtained antenatal care during the pregnancy and whether

they had taken iron supplements and folic acid while pregnant. For each birth, the mothers were also asked what type of assistance they received at the time of delivery. Table 7 presents the information on these key maternity care indicators.

Antenatal Care

Antenatal care from a trained provider is important to monitor the pregnancy and reduce risks for the mother and infant during pregnancy and at delivery. Ninety-eight percent of mothers reported seeing a health professional at least once for antenatal care for the most recent birth in the five-year period before the survey. Coverage is almost uniformly high among mothers regardless of any background characteristics shown in Table 7. This high coverage does not vary significantly from the estimated coverage in Moldova in 1997 (CDC and MOH, 1998).

Table 7. Maternal care indicators

Percentage of women who had a live birth in the five years preceding the survey who received specific maternal health services during pregnancy for the most recent birth, and among all live births in the five years before the survey, percentage delivered by a health professional and percentage delivered in a health facility, by background characteristics, Moldova 2005

Background characteristic	Percentage with antenatal care from a health professional[1]	Percentage who took iron tablets syrup during pregnancy	Percentage who took folic acid during pregnancy	Number of women	Percentage delivered by a health professional[1]	Percentage delivered in a health facility	Number of births
Mother's age at birth							
<20	98.7	48.4	16.2	173	100.0	100.0	212
20-34	98.0	55.5	21.7	1,142	99.5	98.8	1,301
35+	97.2	42.1	11.4	72	98.9	98.9	78
Birth order							
1	98.4	54.9	21.5	1,154	99.5	98.9	1,154
2-3	96.3	49.8	15.4	229	99.5	99.1	415
4+	*	*	*	5	*	*	22
Residence							
Urban	97.8	62.2	26.2	566	99.6	99.9	611
Rural	98.3	48.3	16.5	821	99.5	98.4	980
Region							
North	99.0	49.7	22.6	424	100.0	99.4	473
Center	97.5	49.2	12.0	386	99.1	98.3	464
South	97.9	46.5	15.8	264	99.4	98.4	317
Chisinau	97.6	71.8	32.0	313	99.5	99.7	337
Education							
No education	*	*	*	5	*	*	6
Primary	*	*	*	8	*	*	9
Secondary	98.1	45.0	14.9	883	99.4	98.6	1,037
Secondary special	99.1	65.8	29.4	209	100.0	99.4	229
Higher	97.3	74.3	31.6	283	99.7	99.7	310
Total	98.1	53.9	20.5	1,387	99.5	98.9	1,591

[1] Doctor, nurse, midwife, or auxiliary midwife
* Replaces figures that are based on fewer than 25 unweighted cases

Moldova fares well in providing antenatal care. Compared with estimates from recent Reproductive Health Surveys and Demographic and Health Surveys conducted in other countries in Eastern Europe and Eurasia, Moldova is among countries with the highest coverage of antenatal care by a trained provider: Romania (89 percent in 1999), Ukraine (90 percent in 1999), Armenia (92 percent in 2000), Azerbaijan (70 percent in 1999), Georgia (91 percent in 1999), Kazakhstan (95 percent in 1999), (97 percent in 1997), Turkmenistan (98 percent in 2000), and Uzbekistan (95 percent in 1996) (CDC and ORC Macro, 2003).

Iron and Folic Acid Supplements

Mothers are recommended to take iron supplements during pregnancy since maternal anaemia is a principal cause of both maternal and neonatal mortality. Table 7 shows slightly more than half (54 percent) of mothers receive iron supplements during pregnancy. Coverage varies as expected by residence and education. Mothers that live in urban areas (62 percent), and especially in Chisinau (72 percent), are more likely to take iron supplements than women in rural areas (48 percent). Prevalence also increases significantly with increasing education; 74 percent of women with higher education take iron supplements compared with only 45 percent with secondary education.

Only about one-fifth of mothers take folic acid during pregnancy. Low coverage can be partially attributed to the fact that only 39 percent of mothers reported that they ever heard of folic acid. The differentials by background characteristics are similar to those pertaining to iron supplements: women age 20-34 years are more likely to take folic acid than younger or older mothers; first-time mothers are more likely to take folic acid than mothers that have already had children; mothers in urban areas, and especially Chisinau, are most likely to take folic acid; and mothers with more education are more likely to take it.

Delivery Care

Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that can cause the death or serious illness of the mother and/or the infant. Table 7 shows that virtually all births in Moldova are delivered by a health professional; similarly, almost all deliveries take place in health facilities. Differentials in delivery care vary little by background characteristics of the mother.

Estimates from recent Reproductive Health Surveys and Demographic and Health Surveys conducted in other countries in Eastern Europe and Eurasia show that most countries in the region also have over 95 percent of women assisted by a health professional at the time of delivery and they deliver in a health facility. Azerbaijan (2001) is the main exception, where only 88 percent of women are assisted by a health professional and only 74 percent give birth in a health facility (CDC and ORC Macro, 2003).

Postnatal Care

A crucial component of safe motherhood is postnatal care. Postnatal checkups provide an opportunity to assess and treat delivery complications and to counsel mothers on how to care for themselves and their children.

Figure 3 shows that the vast majority of women have timely checkups after delivering. Eighty-nine percent of all women with a birth in the past five years received a medical checkup within two days, and another 6 percent within the next six weeks. Only 4 percent of women overall reported not receiving any checkup after delivery; the level of those not receiving a checkup is highest in the North region where 6 percent were not seen by a trained provider. Surprisingly, medical checkups are more likely to happen, and more likely to be timely, in rural areas than urban areas. In all tables, urban comes on top, but here it is lower than rural.

Figure 3

Postnatal care of mother from trained providers by timing of PNC

Note: data shown do not include 1.2 percent of missing cases

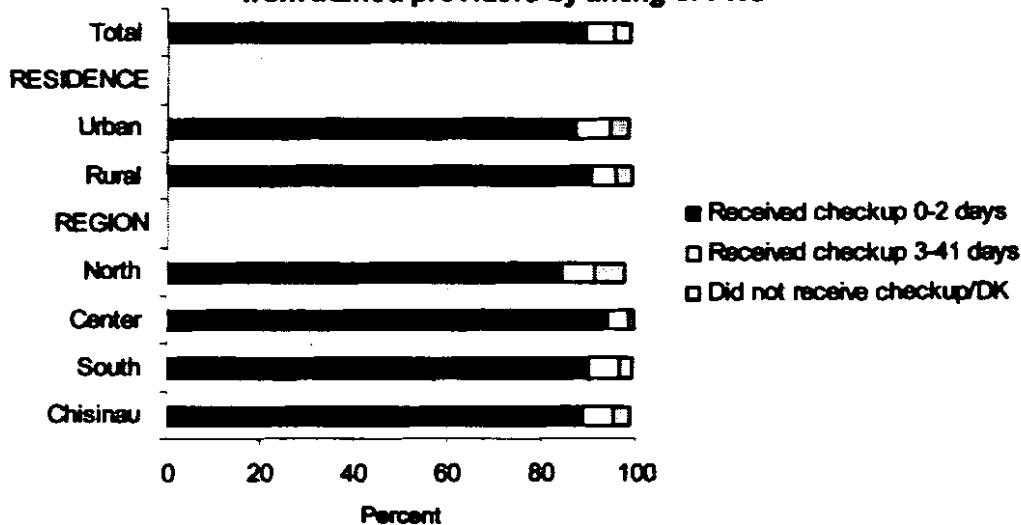Coverage of postnatal care has improved in Moldova since 1997, when only 74 percent of mothers reported receiving a postnatal checkup (CDC and MOH, 1998). Compared with estimates from recent Reproductive Health Surveys and Demographic and Health Surveys conducted in other countries in Eastern Europe and Eurasia, Moldova fares better than other countries in the region in providing postnatal examinations. In Romania (1999), 32 percent of mothers received postpartum care, in Ukraine, 58 percent, in Azerbaijan, 25 percent, and in Georgia, 1 percent (CDC and ORC Macro, 2003).

H.   Child Health

Vaccination of Children

According to the World Health Organization, a child is considered fully vaccinated if he or she has received a BCG vaccination to prevent tuberculosis, three doses of DPT to prevent diphtheria, pertussis, and tetanus, at least three doses of polio vaccine, and one dose of measles vaccine. The vaccination schedule followed by the National Immunization Program of the Republic of Moldova provides all vaccinations mentioned above as well as vaccination against Hepatitis B (three doses) and against mumps and rubella. The last two are given as one injection of combined measles-mumps-rubella (MMR) vaccine. All vaccinations should be received during the first year of life, except MMR, which is given at the age of 12 months. Taking into consideration this vaccination schedule, full immunization coverage was estimated in the birth cohort 15-26 months of age, allowing a reasonable interval of three months for children to receive the MMR vaccination.

The information on vaccination coverage was obtained for all children under five years. In Moldova, child health records are routinely maintained in the local health facilities. "Vaccination certificates," kept in the possession of the child's parent or guardian, became available in 2002. In this survey, data were collected from both sources, as well as the mother's verbal report. All mothers were asked to show the interviewer the vaccination certificate or other health card used for the child's immunization. If the certificate or health card was available, the interviewer copied the dates of each immunization received in the questionnaire instrument. Then the interviewer proceeded to ask the mother if the child had received BCG, polio, DPT, hepatitis B, measles, mumps and/or rubella vaccines, and how many doses were received. After completing the interview in the household and collecting information about the address of the local health facility where the child's immunization record is kept,

interviewers visited that health facility in order to obtain the child's immunization information from that source.

Vaccination certificates at home were seen for 13 percent of children and immunization cards at the health facility were seen for 86 percent of children. Combined information from certificates and health cards was 90 percent (in some cases both sources of information were seen for a child).

Table 8 presents information on vaccination coverage for children age 15-26 months, who should be fully vaccinated against the nine preventable childhood diseases. The results are based on the combination of sources including the vaccination certificate at home, the child's record at the health facility, and information recalled by mother.

Table 8. Vaccinations by background characteristics

Percentage of children age 15-26 months who received specific vaccines at any time before the survey (according to a vaccination card at local clinic, a health card in the household, or by the mother's report), and percentage with a vaccination card seen, by background characteristics, Moldova 2005

Background characteristic	BCG	Hepatitis B			DPT			Polio			Measles	Mumps	Rubella	Fully vacci- nated[1]	Percentage with a vaccination card at home or at clinic	Number of children
		1	2	3	1	2	3	1	2	3						
Sex																
Male	100.0	97.8	96.7	92.8	99.4	98.5	94.2	99.4	99.1	95.9	90.8	90.9	89.4	84.3	89.8	159
Female	99.5	97.7	97.0	95.1	97.3	94.6	90.8	98.9	96.8	93.0	90.3	88.0	88.0	84.4	89.5	170
Birth order																
1	100.0	99.3	98.2	95.8	99.3	97.0	92.9	99.6	98.5	95.3	92.9	91.5	90.9	86.4	90.0	259
2-3	98.7	91.7	91.7	88.2	94.3	94.3	91.2	97.3	95.6	91.9	81.2	81.2	80.0	77.0	88.0	68
4+	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	2
Residence																
Urban	100.0	100.0	97.8	91.6	98.6	94.0	88.9	99.2	97.0	92.3	88.1	85.9	85.2	78.2	90.4	128
Rural	99.6	96.3	96.3	95.6	98.1	98.1	94.7	99.1	98.5	95.8	92.1	91.6	90.9	88.3	89.2	201
Region																
North	100.0	94.7	94.7	92.0	97.7	96.8	91.0	97.7	97.3	93.4	91.5	91.5	91.5	84.4	85.3	102
Center	99.2	98.0	96.9	96.3	98.0	97.4	93.9	100.0	98.2	94.8	90.9	88.5	88.5	86.4	93.1	104
South	100.0	100.0	98.6	96.5	100.0	99.0	96.6	100.0	99.0	95.2	94.7	94.7	94.7	88.7	91.5	54
Chisinau	100.0	100.0	98.7	91.6	98.1	92.7	89.1	99.2	97.5	94.8	85.4	83.4	80.1	77.6	89.5	69
Education																
Primary	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	3
Secondary	99.6	97.0	96.5	94.0	98.2	96.6	92.4	98.6	97.3	94.4	90.2	88.5	88.1	84.1	92.8	210
Secondary special	100.0	100.0	100.0	97.1	100.0	100.0	94.3	100.0	100.0	94.3	91.7	91.7	91.7	87.7	84.9	51
Higher	100.0	98.2	95.7	91.2	97.0	93.2	90.7	100.0	98.2	94.4	91.4	91.0	88.8	82.8	83.7	66
Total	99.7	97.7	96.9	94.0	98.3	96.5	92.4	99.1	97.9	94.4	90.6	89.4	88.7	84.3	89.7	329

[1] A fully vaccinated child in Moldova has one dose of BCG, three doses of HepB, three doses of DPT, three doses of polio, and one dose of measles, mumps and rubella.
* Replaces figures that are based on fewer than 25 unweighted cases

Overall, 84 percent of children 15-26 months are fully vaccinated, and there are no children reported who never received any vaccines. Regarding coverage for specific vaccines, more than 98 percent of children have received the BCG vaccination, the first dose of HepB, DPT, and polio vaccines (polio 1) reveals high access of children to immunizations. Coverage declines slightly for subsequent doses, with 94 percent of children receiving the recommended three doses of HepB, 92 percent receiving the recommended three doses of DPT, and 94 percent receiving all three doses of polio. The proportion of children vaccinated against measles is 91 percent and the proportion of those vaccinated against

mumps and rubella is 89 percent. The decline in coverage levels reflects dropout rates of 6 percent for DPT, 4 percent for HepB, and 5 percent for polio. The dropout rate represents the proportion of children who receive the first dose of a vaccine but do not go on to get the third dose.

Differentials in coverage levels show that the proportion of children fully vaccinated falls below 80 percent for children of second or higher birth order. Similarly, the proportion of children fully vaccinated in the Chisinau region and in urban areas also falls below 80 percent. There is little variation of vaccination coverage in Moldova depending on mother's education and sex of the child. The highest dropout rates (up to 10 percent) are registered in urban areas and in the Chisinau region, which calls attention to issues related to continuity of immunization services in those areas.

Treatment of Childhood Illnesses

Acute respiratory illness, fever and dehydration from severe diarrhoea are major causes of childhood morbidity and mortality. Prompt medical attention for children experiencing the symptoms of these illnesses is, therefore, crucial in increasing child well-being and reducing child deaths. To obtain information on how childhood illnesses are treated, mothers were asked (for each child under five years) whether in the two weeks before the survey the child had experienced cough with short, rapid breathing (symptoms of an acute respiratory infection), fever and diarrhoea.

Among all children under five years of age, 16 percent were reported to have had a fever, 7 percent had a cough with short, rapid breathing, and 7 percent had diarrhoea within the two-week period preceding the MDHS (Figure 4). Table 9 shows treatment sought for children with these illnesses. Among children with ARI symptoms, just over half (55 percent) were taken for treatment at a health facility. Among children with diarrhoea, 42 percent were taken for treatment at a health facility; one-third were given a solution made from oral rehydration salt (ORS) packets. More than half of the children with diarrhoea (60 percent) were at least treated with oral rehydration therapy, whether it was solution prepared from ORS packets, a home-prepared solution, or simply extra fluids.

Figure 4.
Illnesses in two weeks preceding the survey
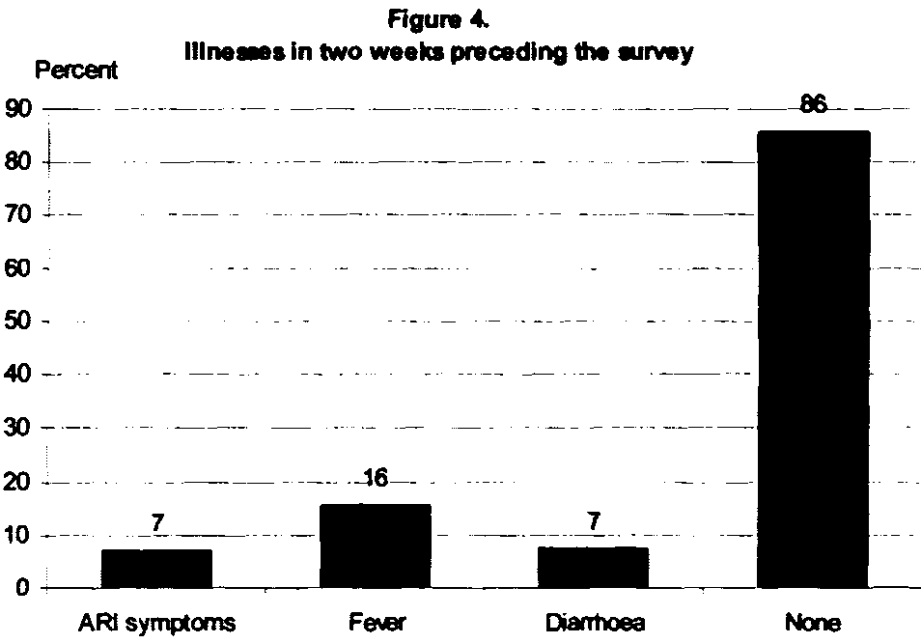
Treatment for ARI and fever symptoms was equally sought for children of either sex. For most other background characteristics, and virtually all background characteristics for diarrhoea except sex, significant variations by categories should not be inferred since the number of cases is too few to be statistically reliable.

Table 9. Treatment for acute respiratory infection, fever, and diarrhoea

Among children under five years who were sick with a cough accompanied by short, rapid breathing (symptoms of acute respiratory infection - ARI) or fever in the two weeks preceding the survey, percentage for whom treatment was sought from a health facility or provider, and among children under five years who were sick with diarrhoea during the two weeks preceding the survey, percentage for whom treatment was sought from a health facility or provider, percentage given a solution made from oral rehydration salt (ORS) packets, and percentage given any oral rehydration therapy (ORT), by background characteristics, Moldova 2005

	Children with symptoms of ARI or with fever		Children with diarrhoea			
Background characteristic	Percentage for whom treatment was sought from a health facility[1]	Number with ARI/ fever	Percentage for whom treatment was sought from a health facility[1]	Percentage given solution from ORS packet	Percentage given any ORT[2]	Number with diarrhoea
Age in months						
<6	*	9	*	*	*	13
6-11	[57.5]	30	*	*	*	21
12-23	64.5	74	[50.2]	[38.9]	[62.7]	40
24-35	48.0	66	*	*	*	21
36-47	64.2	55	*	*	*	12
48-59	[33.4]	45	*	*	*	10
Sex						
Male	55.3	129	37.6	34.0	59.8	47
Female	54.7	151	44.7	32.8	60.8	70
Residence						
Urban	61.3	139	44.2	31.0	55.8	70
Rural	48.7	140	[38.2]	[36.6]	[67.2]	47
Region						
North	53.9	80	[40.2]	[40.0]	[58.7]	38
Center	54.2	64	*	*	*	22
South	[39.0]	42	*	*	*	18
Chisinau	63.6	94	[42.4]	[24.2]	[55.3]	38
Mother's education						
No education	*	2	*	*	*	3
Primary	*	3	*	*	*	3
Secondary	46.5	153	40.3	31.5	56.5	63
Secondary special	[66.2]	43	*	*	*	15
Higher	65.0	77	[40.8]	[29.3]	[59.2]	32
Total	55.0	279	41.8	33.3	60.4	117

[1] Excludes pharmacy, shop, and traditional practitioner
[2] Includes ORS, recommended home fluid, or increased fluids
* Replaces figures that are based on fewer than 25 unweighted cases
[ ] Figures that are based on 25-49 unweighted cases

I. Nutrition

Breastfeeding and Supplementation

Breastfeeding enhances the early bonding and socialization experience of an infant. In addition, breast milk is uncontaminated and contains all the nutrients needed by children in the first four to six months of life. Children who are exclusively breastfed receive *only* breast milk. Exclusive breastfeeding is recommended during the first 6 months of a child's life because it limits exposure to disease agents as well as providing all of the nutrients that a baby requires. Table 10 shows the breastfeeding practices of mothers of children under three years of age.

Table 10. Breastfeeding status by age

Percent distribution of youngest children under three years living with the mother by breastfeeding status and percentage of children under three years using a bottle with a nipple, according to age in months, Moldova 2005

Age in months	Not breast-feeding	Breastfeeding and consuming: Exclusively breastfed	Plain water only	Water-based liquids/ juice	Other milk	Comple-mentary food	Other liquid/ food	Total	Number of children	Percentage using a bottle with a nipple[1]	Number of children
<2	[2.3]	[66.1]	[0.0]	[3.6]	[11.8]	[11.5]	[4.8]	100.0	36	[14.9]	36
2-3	17.2	52.2	9.5	2.5	1.8	13.2	3.6	100.0	64	37.4	64
4-5	19.5	24.6	2.7	5.9	5.1	35.0	7.2	100.0	56	46.3	56
6-7	[19.8]	[13.9]	[2.0]	[4.3]	[2.8]	[57.2]	[0.0]	100.0	41	[48.2]	44
8-9	24.2	2.7	0.0	1.7	0.0	71.4	0.0	100.0	64	51.3	64
10-11	32.3	0.0	1.1	0.0	0.0	66.6	0.0	100.0	50	42.6	51
12-15	59.2	0.0	0.0	0.0	0.0	40.8	0.0	100.0	132	45.8	134
16-19	81.3	1.7	0.0	0.0	0.0	17.0	0.0	100.0	113	36.1	116
20-23	97.6	0.0	0.0	0.0	0.0	2.4	0.0	100.0	94	17.4	105
24-27	97.3	0.0	0.0	0.0	0.0	2.7	0.0	100.0	96	8.7	106
28-31	97.0	0.0	0.0	0.0	0.0	3.0	0.0	100.0	106	4.7	115
32-35	100.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	88	11.2	107
<6	14.6	45.5	4.9	4.0	5.3	20.6	5.1	100.0	157	35.4	157
6-9	22.5	7.1	0.8	2.7	1.1	65.8	0.0	100.0	104	50.1	108

Note: Breastfeeding status refers to a "24-hour" period (yesterday and last night). Children classified as breastfeeding and consuming plain water only consume no supplements. The categories of not breastfeeding, exclusively breastfed, breastfeeding and consuming plain water, water-based liquids/juice, other milk, and complementary foods (solids and semi-solids) are hierarchical and mutually exclusive, and their percentages add to 100 percent. Thus children who receive breast milk and water-based liquids and who do not receive complementary foods are classified in the water-based liquid category even though they may also get plain water. Any children who get complementary food are classified in that category as long as they are breastfeeding as well.
[1] Based on all children under three years
[ ] Figures that are based on 25-49 unweighted cases

Eighty-five percent of children under six months in Moldova are breastfed. The duration of breastfeeding, however, is not long; already at 12 to 15 months, well over half of children (59 percent) are no longer being breastfed. By 20 to 23 months, almost all children have been weaned.

Exclusive breastfeeding is less common, and supplementary feeding begins early. Less than half of children (46 percent) under 6 months are exclusively breastfed, and the remainder of breastfed children consume water-based liquids or juice, or other milk in addition to breast milk. By age 6 to 9 months, most breastfeeding children are receiving complementary foods in addition to breast milk.

Bottle feeding is fairly widespread in Moldova; more than one-third (37 percent) of infants 2 to 3 months old are fed with a bottle with a nipple. This proportion climbs to 51 percent for children age 8 to 9 months before beginning to drop off.

Compared with estimates from recent Reproductive Health Surveys and Demographic and Health Surveys conducted in other countries in Eastern Europe and Eurasia. the prevalence of breastfeeding in Moldova is relatively low: 89 percent of children were ever breastfed in Armenia (1999); 95 percent in Azerbaijan (2001); 89 percent in Kazakhstan (1999); 89 percent in Kyrgyz Republic (1997); 96 percent in Turkmenistan (2000); and 92 percent in Uzbekistan (1996). The prevalence in Armenia (2000) is 85 percent, the same as the current estimate in Moldova (CDC and ORC Macro, 2003).

Nutritional Status of Children

Undernutrition places children at increased risk of morbidity and mortality and has also been shown to be related to impaired mental development. Anthropometry provides one of the most important indicators of children's nutritional status. Height and weight measurements were obtained for all children born in the five years preceding the 2005 MDHS (Table 11). The height and weight data are used to compute three summary indices of nutritional status: height-for-age; weight-for-height; and weight-for-age. These three indices are expressed as standard deviation units from the median for the international reference population recommended by the World Health Organization. Children who fall more than two standard deviations (-2 SD) below the reference mean are regarded as undernourished, while those who fall more than three standard deviations (-3 SD) below the reference median are considered severely undernourished. Table 11 shows the nutritional status among children under five years of age by selected background characteristics.

Children whose height-for-age is below minus two standard deviations from the median of the reference population are considered stunted or short for their age. Stunting is the outcome of failure to receive adequate nutrition over an extended period and is also affected by recurrent or chronic illness. Eight percent of children under five are short for their age and approximately two percent are severely stunted.

Children whose weight-for-height is below minus two standard deviations from the median of the reference population are considered wasted or thin. Wasting represents the failure to receive adequate nutrition in the period immediately before the survey and typically is the result of recent illness episodes, especially diarrhoea, or of a rapid deterioration in food supplies. In Moldova, about 4 percent of children were wasted at the time of the survey and about 1 percent were severely wasted.

Children whose weight-for-age is below minus two standard deviations from the median of the reference population are considered underweight. The measure reflects the effects of both acute and chronic undernutrition. Approximately 4 percent of children were underweight at the time of the survey and about 1 percent were severely wasted.

Compared with estimates from recent Reproductive Health Surveys and Demographic and Health Surveys conducted in other countries in Eastern Europe and Eurasia, the prevalence of stunting is lower for children in Moldova than for children in other countries in the region: 11 percent of children under 5 years were stunted in Armenia (1999); 13 percent (of children 3-59 months) in Azerbaijan (2001); 10 percent in Kazakhstan (1999); 25 percent in Kyrgyz Republic (1997); 24 percent in Turkmenistan (2000); and 31 percent in Uzbekistan (1996) (CDC and ORC Macro, 2003).

Table 11. Nutritional status of children

Percentage of children under five years classified as malnourished according to three anthropometric indices of nutritional status: height-for-age, weight-for-height, and weight-for-age, by background characteristics, Moldova 2005

Background characteristic	Height-for-age		Weight-for-height		Weight-for-age		Number of children
	Percentage below -3 SD	Percentage below -2 SD[1]	Percentage below -3 SD	Percentage below -2 SD[1]	Percentage below -3 SD	Percentage below -2 SD[1]	
Age in months							
<6	2.5	6.5	1.6	2.2	0.0	0.9	116
6-9	0.7	6.4	0.9	7.0	0.0	2.7	93
10-11	[1.8]	[9.2]	[2.9]	[2.9]	[1.7]	[1.7]	44
12-23	1.5	12.2	0.6	4.1	0.7	4.1	335
24-35	2.2	7.0	1.0	3.6	0.0	4.4	319
36-47	1.2	6.0	0.8	4.7	0.8	5.0	300
48-59	1.9	9.2	0.0	3.0	0.8	5.9	292
Sex							
Male	1.5	8.1	0.9	3.9	0.8	3.4	764
Female	1.9	8.6	0.6	3.8	0.2	5.2	734
Residence							
Urban	1.9	6.7	0.9	4.0	0.3	2.6	497
Rural	1.6	9.2	0.7	3.8	0.6	5.1	1.001
Region							
North	1.5	6.3	0.4	3.9	0.6	2.4	460
Center	1.1	10.2	1.2	4.9	0.5	6.5	462
South	2.6	11.0	0.2	3.2	0.5	5.6	314
Chisinau	1.9	5.8	1.3	2.9	0.3	2.2	262
Education[2]							
No education	*	*	*	*	*	*	14
Primary	*	*	*	*	*	*	11
Secondary	1.9	9.7	0.5	4.0	0.4	5.6	892
Secondary special	2.0	6.9	0.4	3.9	0.0	1.1	182
Higher	0.6	5.1	1.1	4.2	1.0	2.3	234
Mother's age[2]							
15-19	0.0	4.4	0.0	3.7	0.0	0.0	63
20-24	2.1	9.3	0.5	3.3	0.5	3.9	473
25-29	1.8	9.3	0.8	4.8	0.6	4.3	516
30-34	1.5	7.0	1.7	4.1	0.5	5.5	293
35-49	1.1	6.6	0.0	2.2	0.5	5.0	153
Mother's status							
Mother interviewed	1.7	8.6	0.6	4.0	0.5	4.4	1,319
Mother not interviewed, but in household	*	*	*	*	*	*	18
Mother not interviewed, not in household[3]	2.0	7.1	2.3	3.5	0.9	3.7	157
Total	1.7	8.4	0.8	3.9	0.5	4.3	1,498

Note: Table is based on children who stayed in the household the night before the interview. Each of the indices is expressed in standard deviation units (SD) from the median of the NCHS/CDC/WHO International Reference Population. The percentage of children who are more than three or more than two standard deviations below the median of the International Reference Population (-3 SD and -2 SD) are shown by background characteristics. Table is based on children who have a valid date of birth (month and year) and valid height and weight measurements. Total includes one case for which education level is missing.

[1] Includes children who are below -3 SD

[2] For women who were not interviewed, information is taken from the Household Questionnaire. Excludes children whose mothers were not listed in the household schedule

[3] Includes children whose mothers are deceased

* Replaces figures that are based on fewer than 25 unweighted cases

Nutritional statistics do not vary widely for most background characteristics. For region, however, children are notably more stunted in the Center and South regions than in the North and in Chisinau.

Anaemia

Anaemia is characterized by a low level of haemoglobin in the blood. Haemoglobin is necessary for transporting oxygen from the lungs to other tissues and organs in the body. Anaemia usually results from a nutritional deficiency of iron, folate, vitamin B_{12}, or some other nutrients. This type of anaemia, which is commonly referred to as iron-deficiency anaemia, is the most widespread form of malnutrition in the world. The 2005 MDHS included anaemia testing of children 6 to 59 months old and women age 15-49. The results of anaemia testing are shown in Table 12.

Table 12. Anaemia among children and women					
Percentage of children age 6-59 months and women age 15-49 years classified as having anaemia, by background characteristics, Moldova 2005					
Background characteristic	Any anaemia	Percentage with anaemia			Number
		Mild anaemia	Moderate anaemia	Severe anaemia	
CHILDREN					
Residence					
Urban	26.8	18.4	8.4	0.0	432
Rural	34.7	23.5	11.2	0.0	932
Region					
North	35.3	24.6	10.8	0.0	443
Center	31.1	20.5	10.7	0.0	432
South	35.7	23.8	12.0	0.0	281
Chisinau	22.7	16.4	6.4	0.0	208
Total	32.2	21.8	10.3	0.0	1,364
WOMEN					
Residence					
Urban	24.7	21.3	3.1	0.3	2,832
Rural	30.1	24.7	5.2	0.2	4,155
Region					
North	31.6	25.2	6.2	0.2	2,127
Center	25.9	22.3	3.3	0.3	1,970
South	31.5	26.6	4.6	0.2	1,342
Chisinau	22.3	19.4	2.7	0.2	1,549
Total	27.9	23.3	4.3	0.3	6,987

Note: Table is based on children and women who stayed in the household the night before the interview. Prevalence is adjusted for altitude (for children and women) and smoking (for women) using CDC formulas (CDC, 1998). Women and children with <7.0 g/dl of hemoglobin have severe anaemia, women and children with 7.0-9.9 g/dl have moderate anaemia, and non-pregnant women with 10.0-11.9 g/dl and children and pregnant women with 10.0-10.9 g/dl have mild anaemia.

Overall about one-third of children 6 to 59 months in Moldova have some level of anaemia, including 22 percent of children who are mildly anaemic (10.0-10.9 g/dl) and 10 percent who are moderately anaemic (7.0-9.9 g/dl). There is a higher prevalence of anaemia among children who live in rural areas than urban areas, and more children in the North and South region are affected than in the Center and Chisinau.

The prevalence of anaemia in women is slightly less pronounced among women than among children. Twenty-eight percent of women in Moldova are anaemic, with 23 percent mildly anaemic and 4 percent moderately anaemic. The prevalence of anaemia in women by residence and region varies similarly to that of children: it is more common in rural areas than urban areas, and more in the North and South regions compared with the Center and Chisinau.

Compared with estimates from recent Reproductive Health Surveys and Demographic and Health Surveys conducted in other countries in Eastern Europe and Eurasia, the prevalence of any anaemia among children in Moldova is about the same as for children in Armenia (31 percent in 2000) and Azerbaijan (32 percent in 2001). Children in Central Asia have higher prevalence of anaemia: in Kazakhstan (1999), 48 percent; in Kyrgyz Republic (1997), 50 percent; in Turkmenistan (2000), 44 percent; and in Uzbekistan (1996), 61 percent.

Women in Moldova are less likely to have anaemia compared with women in most other parts of the region: 40 percent of women in Azerbaijan (2001) have some level of anaemia, 36 percent in Kazakhstan (1999), 38 percent in Kyrgyz Republic (1997), 47 percent in Turkmenistan (2000), and 60 percent in Uzbekistan (1996). Prevalence among women in Armenia (2000) is the exception, where only 12 percent have some level of anaemia (CDC and ORC Macro, 2003).

Iodized Salt

Disorders induced by dietary iodine deficiency constitute a major global nutritional concern. A lack of sufficient iodine in the diet may result in disorders such as goitre, hypothyroidism and diminished mental function. Iodine deficiency in the foetus can lead to increased risks of miscarriages, stillbirths, dongenital anomalies, cretinism, and psychomotor defects. Iodine deficiency can be avoided by using salt that has been fortified with iodine.

Data presented in Table 13 show the results of household salt samples that were tested with a solution that detects potassium iodate (test kits furnished by MBI Kits International). Results show that 60 percent of Moldovan households consume adequately iodized salt (15+ ppm), and households in urban areas are much more likely to consume adequately iodized salt than in rural areas (76 percent and 48 percent, respectively). The level of iodization is greatest in Chisinau, where 83 percent of households use iodized salt in their diet, and least in the South region where only 43 percent of households consume iodized salt. Overall coverage has improved since 2000 when only 33 percent of households in Moldova, including Transnistria, consumed adequate quantities of iodized salt (UNICEF and GOM, 2000).

Table 13. Iodized salt					
Percent distribution of households by iodized salt (based on the test), according to residence and region, Moldova 2005					
Residence/ region	Adequately iodized salt (15+ ppm)	Inade- quately or not iodized (<15 ppm)	No salt in HH/ Not tested	Total	Number
Residence					
Urban	75.6	20.9	3.5	100.0	4,444
Rural	48.2	49.2	2.6	100.0	6,651
Region					
North	53.2	44.3	2.5	100.0	3,614
Center	57.5	40.0	2.5	100.0	2,985
South	43.4	52.9	3.7	100.0	2,026
Chisinau	82.9	13.7	3.4	100.0	2,469
Total	59.2	37.9	2.9	100.0	11,095

J. Infant and Child Mortality

Information on infant and child mortality is useful in identifying segments of the population where children are at high risk so that programmes can be designed to increase their chances of survival. Childhood mortality rates are also basic indicators of a country's socioeconomic level and quality of life. Data on the deaths of children were collected from women in the birth history section of the Women's Questionnaire and are used for direct calculations of mortality rates among children under age five:

Neonatal mortality: the probability of dying within the first month of life;
Postneonatal mortality: the difference between infant and neonatal mortality;
Infant mortality: the probability of dying before the first birthday;
Child mortality: the probability of dying between the first and fifth birthday;
Under-five mortality: the probability of dying between birth and the fifth birthday;

All rates are expressed per 1,000 live births, except for child mortality, which is expressed per 1,000 children surviving to 12 months of age.

Table 14 presents early childhood mortality rates in Moldova for the three 5-year periods preceding the survey. These periods coincide approximately with 2000-2005, 1995-1999, and 1990-1994. For the most recent 5-year period before the 2005 MDHS, the level of under-five mortality is 14 deaths per 1,000 births, implying that about 1 in every 70 children born in Moldova during that period died before reaching their fifth birthday. The infant mortality rate is 13 deaths per 1,000 live births, indicating that most all early childhood deaths take place during the first year of life. These estimates compare well to the government estimates in 2002 of 18 deaths under age 5 years per 1,000 births (25 per 1,000 in 1990) and 15 infant deaths per 1,000 live births (19 per 1,000 in 1990) (UNFPA, 2003).

Table 14. Early childhood mortality rates

Neonatal, postneonatal, infant, child, and under-five mortality rates for five-year periods preceding the survey, Moldova 2005

Years preceding the survey	Neonatal mortality (NN)	Postneonatal mortality[1] (PNN)	Infant mortality $(_1q_0)$	Child mortality $(_4q_1)$	Under-five mortality $(_5q_0)$
0-4	5	8	13	1	14
5-9	23	6	29	9	38
10-14	12	9	20	7	27

[1] Computed as the difference between the infant and neonatal mortality rates

Figure 5 shows that for the period 5 to 9 years prior to the survey (1995-1999), neonatal mortality is high compared with other periods. Consequently, since neonatal mortality is a component of infant mortality and under-five mortality, these rates are also higher relative to other periods. A more detailed analysis will be necessary to identify possible factors influencing neonatal mortality during the late 1990s: Was there a crisis in the health system? Was there a change in reproductive health legislation? Did Moldova's quality of life take a drastic turn for the worse? Was there a change in the reporting system such that more dead children were registered relative to other periods? A more detailed analysis of mortality data, its quality, and differentials will be presented in the final report.

Figure 5.
Early childhood mortality rates
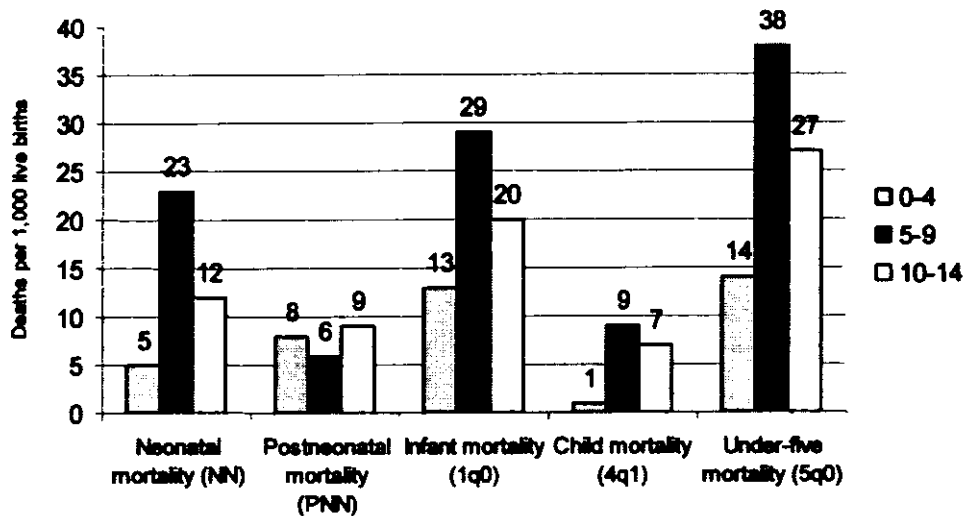
Compared with estimates from recent Reproductive Health Surveys and Demographic and Health Surveys conducted in other countries in Eastern Europe and Eurasia, children's survival probabilities in Moldova are relatively high. The following infant mortality estimates are for the 0- to 4-year period preceding the date of the surveys, which correspond most closely with the 5- to 9-year period prior to the 2005 MDHS survey (IMR in Moldova 5 to 9 years prior to the survey is 29 deaths per 1,000 live births): the IMR in Romania 0 to 4 years prior to the survey in 1999 is 32 per 1,000; in Armenia (2000), 36 per 1,000; in Azerbaijan (2001), 74 per 1,000; in Georgia (1999), 42 per 1,000; in Kazakhstan (1999), 62 per 1,000; in Kyrgyz Republic (1999), 62 per 1,000; in Turkmenistan (2000), 74 per 1,000; and in Uzbekistan (1996), 49 per 1,000 (CDC and ORC Macro, 2003). It should be noted that Moldova's official IMR estimates do not appear to be biased by underreporting of deaths to the extent that other countries in the region are. All countries aforementioned exceed official rates by 50 percent (Romania 1999) to 330 percent (Azerbaijan 2001). It is generally understood that official rates in those countries are underestimated due to not using the WHO (1993) standard definition of a live birth, as well as other defects in the registration system (Notzon et al., 1999).

As another point of reference, the Population Reference Bureau publishes recent infant mortality rates for all countries. The following PRB estimates for IMR estimates correspond to "some point in the late 1990s and early 2000s": in Eastern Europe, the IMR in Romania is 17 deaths per 1,000 live births, in Russia 12, in Ukraine 10, in Belarus 8, in Hungary 7, and in Moldova 14; in the Caucasus, the IMR in Armenia is 36, in Azerbaijan 10 (keeping in mind the gross underreporting for this country, mentioned above), and in Georgia 25; and in Central Asia, the IMR in Kazakhstan is 61, in Kyrgyz Republic 55, in Tajikistan 89, in Turkmenistan 74, and in Uzbekistan 62. These rates are primarily from official country sources, and the *2005 World Population Data Sheet* should be referred to for specific sources (PRB, 2005).

K.   HIV/AIDS

The 2005 MDHS included a series of questions that addressed respondents' knowledge about AIDS and their awareness of modes of transmission of the human immunodeficiency virus (HIV) that causes AIDS and of behaviours that can prevent the spread of HIV.

Table 15 shows that general awareness of AIDS is nearly universal among men and women in the reproductive ages in Moldova. However, only 37 percent of women and 25 percent of men believe that there is a way to avoid the virus causing AIDS. Differences by age and marital status are minimal, except for men over age 50 who are the least likely to believe that there is a way to avoid HIV/AIDS. Differences are more pronounced by region, especially for men. In urban areas, 31 percent of men believe the virus can be avoided while only 21 percent in rural areas do. Likewise, men in Chisinau are more aware than men in other region that there are ways to avoid contracting the virus. Women in the Center region, outside of Chisinau, are less likely than women in other regions to believe that the virus can be avoided. Both women and men with higher education are more likely to think HIV/AIDS can be avoided than those with secondary or secondary special education.

Table 15. Knowledge of AIDS

Percentage of women and men who have heard of AIDS and believe there is a way to avoid HIV/AIDS, by background characteristics, Moldova 2005

Background characteristic	Women			Men		
	Has heard of AIDS	Believes there is a way to avoid HIV/AIDS	Number	Has heard of AIDS	Believes there is a way to avoid HIV/AIDS	Number
Age						
15-19	96.8	34.7	1,417	97.1	25.1	411
20-24	98.8	39.3	1,124	98.6	27.4	275
25-29	97.5	35.5	964	97.0	30.3	234
30-39	97.9	39.1	1,778	99.0	30.2	472
40-49	96.7	34.8	2,156	95.9	24.4	596
50-59	na	na	0	94.7	18.6	519
Marital status						
Never married	97.2	38.7	1,862	97.5	26.1	730
Married or living together	97.5	36.2	4,937	96.7	24.9	1,657
Divorced/separated/widowed	97.5	33.1	641	95.1	25.6	120
Residence						
Urban	99.2	37.9	3,194	98.5	30.8	1,055
Rural	96.1	35.6	4,246	95.6	21.3	1,453
Region						
North	97.7	38.8	2,207	96.6	22.9	756
Center	95.3	29.5	2,033	96.8	24.1	702
South	97.7	38.4	1,402	94.0	21.1	496
Chisinau	99.2	40.4	1,798	99.8	33.7	554
Education						
No education	*	*	*	*	*	3
Primary	*	*	*	*	*	13
Secondary	96.1	29.6	4,544	96.1	20.5	1,787
Secondary special	99.8	43.8	1,327	99.5	29.6	302
Higher	99.9	51.9	1,530	99.7	44.0	403
Total	97.4	36.6	7,440	96.8	25.3	2,508

Note: Total includes one case where education is missing
na = Not applicable
* Replaces figures that are based on fewer than 25 unweighted cases

Awareness of HIV/AIDS has not varied among women of reproductive age in Moldova since the 1997 RHS (no comparative data are available for men) (CDC and MOH, 1998; UNICEF and GOM, 2000). Compared with estimates from recent Reproductive Health Surveys and Demographic and Health Surveys conducted in other countries in Eastern Europe and Eurasia, women and men in neighbouring Romania (1999) and women in Ukraine (1999) are equally likely to have heard of the infection. In the Caucasus and Central Asia, however, fewer women have heard of it: 58 percent of

women in Armenia (2000); 66 percent in Azerbaijan (2001); 89 percent in Georgia (1999); 82 percent in Kazakhstan (1999) and 86 percent in Turkmenistan (2000) (CDC and ORC Macro, 2003).

Use of Condoms

The AIDS prevention initiative focuses its messages and efforts on three important aspects of behaviour summed up in the ABC approach: Abstinence (outside of marriage), Be faithful (to one partner), and Use Condoms (in high-risk sexual relationships) (Shelton et al., 2004). The 2005 MDHS asked a series of questions to men and women related to these behaviours in order to monitor certain HIV/AIDS indicators.

Tables 16.1 and 16.2 present information on condom use among women and men during last sexual encounter, by type of partner. With respect to the last sexual encounter regardless of partner type, men (18 percent) are about twice as likely as women (10 percent) to report use of a condom. Both women and men are far less likely to use a condom during sex with a cohabiting partner (6 percent and 7 percent, respectively) than during sex with a noncohabiting partner (34 percent and 51 percent, respectively).

Table 16.1 Use of condoms by type of partner: women

Among women who have had sexual intercourse in the past year, percentage who used a condom during last sexual intercourse with spouse or cohabiting partner, with noncohabiting partner, and with any partner, by background characteristics, Moldova 2005

Background characteristic	Spouse or cohabiting partner		Noncohabiting partner		Any partner	
	Percent	Number	Percent	Number	Percent	Number
Age						
15-19	14.9	125	48.7	157	33.8	279
20-24	9.4	593	40.7	234	18.1	822
25-29	10.4	765	27.9	102	12.6	858
30-39	6.8	1,505	24.0	116	8.0	1,614
40-49	2.4	1,707	12.0	104	2.8	1,804
Marital status						
Never married	35.5	4	42.5	353	42.5	356
Married or living together	6.2	4,622	32.6	158	7.0	4,751
Divorced/separated/widowed	11.3	70	19.2	201	17.3	269
Residence						
Urban	10.2	1,895	35.6	468	15.1	2,344
Rural	3.7	2,800	30.1	245	5.8	3,032
Region						
North	4.8	1,467	35.6	139	7.5	1,597
Center	4.6	1,288	21.5	141	6.1	1,423
South	3.5	925	34.1	112	6.8	1,033
Chisinau	13.3	1,015	38.2	321	19.1	1,324
Education						
No education	*	*	*	*	*	15
Primary	*	*	*	*	*	18
Secondary	4.2	2,784	28.1	305	6.5	3,073
Secondary special	5.2	996	31.1	111	7.8	1,103
Higher	14.3	887	40.7	291	20.7	1,167
Total	6.3	4,695	33.7	712	9.9	5,376

Note: Total includes one case for which education is missing.
na = Not applicable

Table 16.2 Use of condoms by type of partner: men

Among men who have had sexual intercourse in the past year, percentage who used a condom during last sexual intercourse with spouse or cohabiting partner, with noncohabiting partner, and with any partner, by background characteristics, Moldova 2005

Background characteristic	Spouse or cohabiting partner		Non cohabiting partner		Any partner	
	Percent	Number	Percent	Number	Percent	Number
Age						
15-19	55.2	11	68.7	159	67.0	165
20-24	19.3	69	57.8	178	45.9	239
25-29	12.6	163	44.9	68	21.6	219
30-39	8.0	385	45.6	76	11.7	439
40-49	4.4	464	21.5	62	5.2	509
50-59	1.7	365	9.1	32	2.0	389
Marital status						
Never married	55.6	19	60.6	397	59.8	410
Married or living together	6.0	1,434	35.4	104	6.2	1,474
Divorced/separated/widowed	22.0	4	21.5	73	21.5	77
Residence						
Urban	10.0	598	50.8	291	22.5	853
Rural	4.3	858	51.3	284	14.6	1,107
Region						
North	4.6	463	51.0	157	14.8	604
Center	3.9	396	51.4	135	14.9	511
South	4.5	291	47.8	107	15.0	386
Chisinau	15.5	306	52.8	175	28.2	459
Education						
No education	*	*	*	*	*	2
Primary	*	*	*	*	*	5
Secondary	5.1	996	50.5	382	16.6	1,339
Secondary special	8.1	211	45.3	55	13.2	253
Higher	12.0	243	54.7	136	26.8	362
Total	6.7	1,457	51.1	574	18.0	1,961

na = Not applicable
* Replaces figures that are based on fewer than 25 unweighted cases

There are significant differentials for both men and women in the likelihood that a condom was used in the last sexual encounter, particularly when the encounter involved a noncohabiting partner. Younger women, never-married women, urban women, and women living in Chisinau are much more likely than other women to report use of a condom during sex with a noncohabiting partner. For example, the reported use among never-married women (43 percent) is more than double as high as among formerly married women (17 percent). The reported level of condom use during sexual encounters with any partner rises sharply with the woman's educational level, from 7 to 8 percent of women with secondary or secondary special education to 21 percent of those with higher education. The pattern is similar among men, with higher condom use associated with young age, unmarried status, urban residence, and higher education.

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